STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245291	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Clare Living Community of Mora	110 North 7th Street Mora, MN 55051

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on observation, interview and document review, the facility failed to ensure residents were comprehensively assessed for self-administration of medications for 2 of 2 residents (R3, R10) reviewed and observed for self-administration of medications. Findings include: R3 R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R3 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R3's diagnoses included heart failure, chronic kidney disease, generalized anxiety disorder, chronic obstructive pulmonary disease, encephalopathy, hypertension and type II diabetes mellitus and unspecified dementia with psychotic disturbance. R3's physician orders included order for Ipratropium bromide inhalation solution 0.02% - 0.5 mg(milligram) - Inhale 0.5 mg via neb twice daily related to chronic obstructive pulmonary disease. During observation on 2/11/25 at 8:29 a.m., R3 was sitting in her recliner holding the nebulizer mask to her face. Nebulizer cup contained a clear solution and nebulizer machine was running with no staff present in room. During observation on 2/12/25 at 8:07 a.m., R3 was sitting in her recliner holding the nebulizer mask to her face. Nebulizer cup contained a clear solution and nebulizer machine was running with no staff present in room. At 8:15 a.m., R3 turned the nebulizer machine off and placed nebulizer mask on nebulizer machine with a very small amount of clear solution remaining in cup. During record review on 2/11/25, the self-administration of medication assessment, completed on 11/30/24, identified R3 did not wish to self-administer any medications, did not indicate any medications R3 would like to self-administer, and indicated there was no MD order to self-administer medications. Assessment indicated R3 was not appropriate to self-administer any medications. During interview on 2/13/25 at 12:05 p.m., registered nurse (RN)-A confirmed the last self-administration assessment, completed on 11/30/24, indicated R3 was not able to self-administer medications. R10 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10's quarterly MDS dated [DATE], identified R10 had moderate cognitive impairment and required assistance with most ADL's. R10's diagnoses included hypertensive chronic kidney disease, chronic pain, cervicalgia (pain in the neck), anxiety disorder, metabolic encephalopathy, chronic combined systolic and diastolic heart failure, chronic obstructive pulmonary disease and dependence on renal dialysis. R10's physician orders included orders for: 1. Ipratropium-Albuterol inhalation solution 0.5 - 3 mg(milligram)/ml(milliliter) - 3 mL inhale orally three times a day related to chronic obstructive pulmonary disease. 2. Muscle rub (menthyl salicylate-menthol) cream - 15-10% - Muscle rub three times daily to right shoulder related to cervicalgia (pain in the neck). R10's physician orders lacked evidence for an order for eye drops. During observation and interview on 2/10/25 at 4:18p.m., R10 had two bottles of muscle rub cream in room and a bottle of artificial tears eye drops. R10 stated he applied the muscle rub up to three to fours times a day and staff also comes in and applies some. R10 stated he applied it just before surveyor entered room. Muscle rub menthol scent was present in room. R10 stated he applied the eye drops when his eyes were dry and itchy. During observation on 2/11/25 at 7:48 a.m., R10 was sitting in his wheelchair in his room. Two tubes of muscle rub and a bottle of eye drops remained in R10's room. Nebulizer cannister contained a clear solution, approximately 1/4 full, and was standing in an upright position on nebulizer machine. During observation on 2/12/25 at 10:32 a.m., R10 was not in room. Two tubes of muscle rub and a bottle of eye drops remained in R10's room. Nebulizer cannister contained a clear solution, approximately 3/4 full, and was standing in an upright position on nebulizer machine. During observation on 2/12/25 at 6:20 p.m., same amount of clear solution remained in nebulizer cannister from earlier this morning and was standing in an upright position on nebulizer machine. During observation on 2/13/25 at 8:03 a.m., R10 was sitting in his wheelchair in his room. Two tubes of muscle rub and a bottle of eye drops remained in R10's room. Nebulizer cannister contained a clear solution, approximately 3/4 full, and was standing in an upright position on nebulizer machine. During interview on 2/13/25 at 11:45 a.m., R10 stated he just returned to the facility from an appointment and stated he had not completed his nebulizer treatment this morning. During record review on 2/13/25, the self-administration of medication assessment, completed on 2/2/25, identified R10 wanted to self-administer medications, however assessment did not indicate any medications R10 would like to self-administer. Assessment indicated R10 was not appropriate to self-administer any medications and agreed to having nursing store and administer all medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/13/25 at 11:46 a.m., trained medication aide (TMA)-A stated there was one resident on this unit, which was not R3 or R10, that were able to self-administer medications. TMA-A stated if a resident was able to self-administer medications, it would be displayed in the resident's electronic health record (EHR). TMA-A confirmed that R3 and R10 did not have an order to self-administer medications which included nebulizer treatments. TMA-A went to R10's room, confirmed two tubes of muscle rub and one bottle of eye drops were in room and took them out of room. TMA-A confirmed that R10's nebulizer cannister was still full of clear solution and stated she set it up this morning and had reminded him to complete his nebulizer treatment, however confirmed that R10 had not done nebulizer treatment. During interview on 2/13/25 at 11:57 a.m., RN-A confirmed there was no order for self-administration of medication in R10's EHR. RN-A stated the last self-administration assessment, completed on 2/2/25, indicated R10 wanted to self-administer medications but the assessment did not include what medication could be self-administered. RN-A asked TMA-A if R10 was able to administer the eyes drops independently with TMA-A stating that apparently R10 is able to self-administer the eye drops because she had never administered eye drops to R10. RN-A confirmed there was no order for eye drops. During interview on 2/14/25 at 2:02 p.m., director of nursing (DON) stated self-administration of medications assessments are completed by a licensed nurse. DON stated assessments should be completed at time of admission, quarterly, or with a significant change in status. DON confirmed nebulizer treatments set up for a resident to self-administer, when nurse leaves the room, needed to be assessed and a self-administer order would need to be obtained from the provider. It was important for the resident to be assessed for self-administration of medications to ensure the resident understands what the medication is for and is capable to complete the whole process. The facility Self-Administration of Medications policy, dated 3/24, identified residents have the right to self-administer medication if the nursing team has determined that it is clinically appropriate and safe for the resident to do so. 1. As part of the evaluation comprehensive assessment, the nursing team assesses each resident's cognitive and physical abilities to determine whether self-administering medication is safe and clinically appropriate for the resident. 2. The nursing team considers the following factors when determining whether self-administration of medications is safe and appropriate for the resident: a. The medication is appropriate for self-administration. b. The resident is able to read and understand medication labels. c. The resident can follow directions and tell time to know when to take the medication. d. The resident comprehends the medication's purpose, proper dosing, timing, signs of side effects and when to report these to the staff. e. The resident has the physical capacity to open medication bottles, remove medications from a container and to ingest and swallow (or otherwise administer) the medication; and (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. The resident is able to safely and securely store the medication. 3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is reassessed quarterly and is based on changes in the resident's medical and/or decision-making status.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to provide smoking opportunities to promote quality of life and resident choice for 1 of 1 resident (R13) reviewed for choices. Findings Include: R13's Continuity of Care document (CCD) printed 2/11/25, included diagnosis of tobacco use, weakness and dementia without behavioral disturbance. R13's quarterly Minimum Data Set (MDS) dated [DATE], identified R13 had intact cognition. R13's diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy, hypertension, non-Alzheimer's dementia, chronic obstructive pulmonary disease, dysphagia, unspecified mood disorder and peripheral vascular disease. R13's electronic health record (EHR) lacked evidence R13 was asked about or assessed for smoking. Progress note dated 6/17/24, indicated R13 expressed concerns and anger towards someone confiscating her cigarettes. Progress note dated 6/29/24, indicated R13 yelled at multiple staff to take her outside and smoke. When staff refused, R13 went outside by herself and attempted to light a match on the building and was unsuccessful. R13 came back into building and yelled at staff to assist her with lighting her cigarette. When staff refused, R13 began yelling and this went on four different times between the times of 6:30 to 9:30 p.m. Note indicated R13 was feeling up staff for cigarettes and lighters. Progress note dated 7/18/24, indicated R13 wheeled herself outside and was asking visitors who were entering building if they had a cigarette she could have. Progress note dated 8/2/24, indicated R13 was outside smoking and that she had a pack of cigarettes in her sweater. Staff approached R13 and asked for her cigarettes with R13 stating it was her last one. During the time R13 was outside, another staff member went into R13's room and found a pack of cigarettes, took them and placed them in the medication room. R13 approached staff later demanding her cigarettes back and stated staff had no right to invade her privacy and taking her pack of cigarettes. R13 was yelling and cursing at staff. Progress note dated 8/3/24, indicated R13 was very upset about not being able to smoke and that resident is in a decent mood other than being very upset about not being able to smoke. Progress note dated 8/7/24, indicated R13 was yelling and calling staff names. R13 stated that someone stole her cigarettes. Progress note dated 9/1/24, indicated staff assisted R13 with going outside. Staff walked back into the building and looked out window to see R13 attempting to light a cigarette with a lighter. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress note dated 10/6/24, indicated R13 became angry with staff when they told R13 she was not allowed to have a cigarette. R13 began demanding staff to give her a cigarette and stating, someone stole hers. Progress note dated 10/22/24, indicated R13 continually asked staff for cigarettes and when staff refused, R13 yelled and swore at staff. Progress note dated 10/26/24, indicated R13 was seen outside the front entrance smoking. Progress note dated 11/6/24, indicated R13 was outside smoking and when R13 stood us there was a lighter under her leg. Progress note dated 12/19/24, indicated R13 continually asked staff for cigarettes, every 30 minutes, and to take her outside. Progress note dated 12/21/24, indicated R13 continually asked staff for cigarettes and would get angry with staff when they would not give her a cigarette. Progress note dated 12/28/24, indicated R13 had behaviors this evening. R13 was continually asking many staff members for cigarettes and would yell at staff when they would not give her a cigarette. Progress note dated 12/29/24, indicated R13 continually asked staff for cigarettes and to take her outside and sit with her. Note indicated R13 is capable of propelling her wheelchair outside independently and had been asking every 30 minutes. Progress note dated 1/3/25, indicated R13 was alert and oriented and was able to make her own decisions. Note indicated R13 continually will ask staff for cigarettes and for staff to take her outside and can get verbal with staff if she doesn't get the answers she is looking for. Progress note dated 1/28/25, indicated R13 was angry at staff for not allowing her to smoke. Progress note dated 1/28/25, indicated R13 was seen outside smoking a cigarette that she had hidden after continually asking staff for one of her cigarettes. R13 cursed and swore at staff. R13's care plan failed to address wishes to smoke. During interview on 2/11/25 at 12;02 p.m., R13 stated she was a smoker and would smoke if she had the opportunity. R13 stated she had smoked since she was [AGE] years old and was smoking up to the day she was admitted to facility. R13 stated it made her very angry and anxious when she is not able to smoke. During interview on 2/11/25 at 1:47 p.m., nursing assistant (NA)-A stated R13 usually went outside to smoke, however it depends on how often as management has stated she was not allowed to smoke. NA-A stated R13 has asked staff to take her outside and gets upset when staff refuses. NA-A stated a lot of R13's behaviors were from nicotine withdrawal. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/12/25 at 1:36 p.m., NA-B stated R13 is a smoker but she was not allowed to smoke on grounds. NA-B stated R13 becomes angry and would yell in the hallway and common areas when staff told her she cannot smoke. NA-B stated she [R13] would not have behaviors if she was allowed to smoke. NA-B stated cigarettes and lighters have been found in R13's room by other staff who removed them and stored them at nursing station. During interview on 2/13/25 at 11:34 a.m., NA-C stated R13 was rude and would yell at staff. R13 has left facility to buy cigarettes and lighters. NA-C stated R13's behaviors stemmed from her not being able to smoke. During interview on 2/13/25 at 12:13 p.m., registered nurse (RN)-A stated R13 liked to go outside frequently but was not able to as we are a non-smoking facility. RN-A stated R13 had a gruff personality and became angry at staff when they would not allow her to go outside to smoke. RN-A stated R13's behaviors were from her not being able to smoke. During interview on 2/14/25 at 1:43 p.m., social worker (SW) stated R13 had aggressive behaviors, all verbal, that started in the past several months. SW stated R13's behaviors were from R13 not being able to smoke. R13 would be able to go outside to the street to smoke if facility completed an assessment to ensure resident was able and safe to. SW stated R13 was able to make daily choices and decisions. During interview on 2/14/25 at 2:02 p.m., director of nursing (DON) stated the facility was a non-smoking facility. R13 had verbal aggression where she would swear and yell at staff. DON stated R13 would state if I could just have a cigarette, I would be happier. DON stated they had another resident in the past that was allowed to smoke outside and stated if R13 was able to go outside and smoke it might de-escalate the behavior she is exhibiting. The Combined Federal and State [NAME] of Rights document, dated 2/1/17, that was in admission packet, indicated the resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice. The facility Resident Preferences for Customary Routine & Activities policy dated 4/24, indicated the facility recognizes and respects the right of each resident to maintain their customary routines and engage in preferred activities to the greatest extent possible, consistent with their individual care plan, safety, and the rights of other residents. We believe that honoring these preferences contributes to residents' well-being, dignity, and quality of life. This policy aims to ensure that residents' choices regarding their daily schedules, personal habits, and social engagements are acknowledges and supported. The facility Tobacco/Smoke Free policy dated February 2025, indicated resident who do wish to continue to use tobacco, electronic cigarettes, or vape pens will be required to sign out in the Release of Responsibility for Leave of Absence book and go off facility property to use tobacco, electronic cigarettes, or vape pens.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review the facility failed to complete neurological assessments following falls for 2 of 2 residents (R7 and R25) who had unwitnessed falls. Facility also failed to ensure medications were administered per physician's orders for 1 of 2 residents (R30) reviewed for bowel management and failed to ensure vitals were obtained per physician's order for 1 of 1 resident (R30) reviewed for following physician orders. Findings include: R7 R7's quarterly Minimum Data Set (MDS) dated [DATE], identified R7 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R7's diagnoses included unspecified dementia with other behavioral disturbance, malnutrition, depression, varicose veins on right lower extremity with inflammation, peripheral vascular diseases, hypothyroidism, essential hypertension, osteoarthritis and systemic sclerosis. R7's progress note dated 6/5/24 at 1:51 p.m., identified an unwitnessed fall. R7 was heard screaming and staff found her on her knees next to recliner. R7 had a bump on her upper-mid forehead that was purplish in color. Record indicated neurological assessment was initiated but was not thoroughly completed. R7's progress note dated 12/13/24 at 2:51 a.m., identified an unwitnessed fall. R7 was found sitting on floor with back resting against recliner with sheet and blankets wrapped around her. R7's progress note dated 12/13/24 at 8:30 a.m., identified an unwitnessed fall. R7 was found on floor lying on left side. R7 had small bruise on left side of forehead. R7's record lacked evidence neurological assessment were completed after R7's unwitnessed falls on 12/13/24 and indicated the neurological assessment, dated 6/5/24, had four times blank where no neurological assessment was completed making the assessment incomplete: - On 6/5/24 at 2:15 a.m. line was drawn through assessment and had sleeping written through time slot. - On 6/5/24 at 2:45 a.m. line was drawn through assessment and had sleeping written through time slot. - On 6/5/24 at 2:45 p.m. assessment time was blank - On 6/5/24 at 6:45 p.m. assessment time was blank - On 6/5/24 at 11:45 p.m. line was drawn through assessment time and had sleeping written through time slot. (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

R25

R25's quarterly MDS dated [DATE], identified R25 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R25's diagnoses included progressive neurological conditions, Parkinson's disease with dyskinesia (uncontrolled, involuntary movements of the face, arms or legs), non-Alzheimer's dementia, anxiety disorder, adult failure to thrive, severe protein-calorie malnutrition, hypothyroidism and unilateral primary osteoarthritis of left knee.

R25's progress note dated 1/7/25 at 6:30 p.m., identified an unwitnessed fall. R25 was found on floor next to her bed with her face down and her hands under her abdomen and her legs straight. R25 had a large bump above her right outer eye that was purple in color.

R25's Record indicated neurological assessment was initiated but was not thoroughly completed. Neurological assessment, dated 1/7/25, had two times blank where no neurological assessment was completed making the assessment incomplete. At 4:45 p.m. and 5:15 p.m. there was a line drawn through each assessment time and had eating written through time slots.

During interview on 2/14/25 at 10:00 a.m., licensed practical nurse (LPN)-A stated when a resident falls, licensed nursing staff assess the resident and ensure there are no injuries. LPN-A stated if the fall was unwitnessed or if resident hit their head, neurological assessments would be initiated. LPN-A stated she would not wake a resident or interrupt resident when in dining room to complete neurological assessment unless she knew they had hit their head.

During interview on 2/14/25 at 12:51 p.m., clinical manager (CM)-A stated when a resident fell , licensed staff would assess resident by obtaining vital signs, checking range of motion and assessing for injuries. CM-A stated if fall was unwitnessed or if resident hit their head, neurological assessment would be initiated. CM-A stated she would expect staff to wake up resident to complete the neurological assessments as it was important to obtain and monitor for any changes in vital signs of level of consciousness.

During interview on 2/14/25 at 2:02 p.m., director of nursing (DON) stated when a resident fell staff alerted the nurse who would obtain vitals and assess for injury. DON stated when a fall was unwitnessed neurological checks are done every 15 minutes for two times, every 30 minutes for two times, every hour for four times and every four hours for seven times. DON stated she would expect staff to wake the resident up to complete neurological assessment at the scheduled time and to complete assessments even when resident was in the dining room. DON confirmed the neurological assessment for R7's and R25's falls were not completed and neurological assessment for R7's falls on 12/13/24 were not initiated. DON stated neurological assessments were important to complete due to residents being fragile and need to be monitored closely to ensure they are not experiencing a change in condition after a potential head strike.

The facility Fall Protocol policy dated 3/24, indicated if a resident hit head or if hitting of head is unknown, start neuro checks using Neurological Check Observation. Neurological checks are every 30 min x 2, then every 1-hour x 4 hours, then every 4-hours x 24 hours.

Bowel management medication

R30

(continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R30's quarterly MDS dated [DATE], identified R30 had intact cognition and required assistance with activities of daily living (ADL)'s such as transferring, toileting. R30's diagnoses included end stage renal disease, anemia, heart failure, hypertension, peripheral vascular disease, diabetes mellitus, malnutrition, anxiety disorder, depression, chronic obstructive pulmonary disease (COPD), polyneuropathy and paroxysmal atrial fibrillation. During review of R30's electronic medication record (EMR), R30 had the following orders: 1. Senna-docusate sodium oral tablet 8.6-50 mg (milligram) two tablets daily to prevent constipation, 2. Dilaudid (hydromorphone) 2 mg one tablet by mouth every Monday, Wednesday and Friday before dialysis, 3. Dilaudid 1 mg one tablet by mouth every four hours as needed for moderate to severe pain, 4. Senna-docusate sodium oral tablet 8.6-50 mg two tablets by mouth as needed at bedtime once daily for constipation, 5. Docusate sodium 100 mg one capsule by mouth as needed once daily for constipation 6. Bisacodyl suppository 10 mg rectally as needed once daily for constipation. R30's bowel record indicated R30's last bowel movement was on 2/8/25, indicating R30 had not had a bowel movement in six days. During review of R30's electronic health record (EHR), EHR lacked evidence of as needed medications ordered for constipation had not been provided for R30. During interview on 2/10/25 at 2:45 p.m., R30 stated she was constipated due to dialysis, fluid restriction and pain medication she had been receiving. R30 stated she received scheduled Senna, but it helps off and on. R30 stated she had not had a bowel movement in several days. During interview on 2/14/25 at 8:58 a.m., R30 stated she still had not had a bowel movement in several days and she was kind of uncomfortable due to this. During interview on 2/14/25 at 10:00 a.m., LPN-A stated the bowel program they followed included if a resident was on day three with no bowel movement prune juice would be given to resident. On day four of no bowel movement as needed Senna would be administered and on day five of no bowel movement an as needed suppository would be administered. During interview on 2/14/25 at 12:51 p.m., CM-A stated a bowel report was printed every day and expected staff to follow standing orders for constipation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/14/25 at 2:02 p.m., DON stated aides chart resident's bowel movement which relays the information to the nurses. DON stated small bowel movements were not counted. DON confirmed R30's last BM was on 2/8/25. DON stated she expected nursing to follow the protocol and offer PRN medications from the standing house orders which consisted of senna, Colace, suppositories and/or enema. DON stated PRN medications should have been offered especially since R30 was on narcotic medications. DON stated it was important so a resident did not get constipated and/or worst-case scenario could lead to hospitalization , and it also affected her quality of life. The facility Bowel Protocol policy dated 4/24, indicated: Do not apply routine bowel protocol if: -There is blood in resident's stool. -There is significant change in resident's mental status. -Bowel sounds are not heard on assessment. -An abdominal mass of unknown origin is palpated. -Dialysis residents cannot have Milk of Magnesia. Check residents MAR for scheduled or PRN stool softeners/laxatives before starting routine bowel program. Night shift nurse to print/review bowel report after 0500 daily. -Day 3 with no BM give 6-8 ounces of prune juice and document amount accepted in MAR. -Day 4 with no BM results give cc of Milk of Magnesia. -Day 5 with no BM results give Bisacodyl suppository -Day 6 with no BM results give Fleets Enema. -If no results on day 6 the day shift nurse will update MD/NP for further orders and request routine (or change in) med if indicated. Vital Signs During review of R30's electronic health record (EHR), provider notes, dated 2/4/25 indicated R30's heart rate was controlled on Coreg (carvedilol) and blood pressures run soft requiring midodrine on dialysis days. Due to hypotension and dizziness complaints will stop Coreg and monitor heart rate closely. R30's vital sign record indicated R30's last pulse was obtained on 2/1/25, indicating R30 had not had her pulse checked since discontinuation of carvedilol on 2/4/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/14/25 at 2:02 p.m., DON stated any licensed nurse reviews the provider visit notes for orders and confirmed an order for regular pulse checks was completed after discontinuation of medication per provider's order. DON stated R30's last pulse was on 2/1/25. DON stated it was important due to it being a physician's order so it should be followed for resident's health. The facility's Processing of Physician's Orders policy and procedure was requested but was not received.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to ensure proper treatment was provided to maintain hearing for 1 of 1 resident (R10) reviewed for hearing. Findings include: R10's quarterly Minimum Data Set (MDS) dated [DATE], identified R10 had moderate cognitive impairment and required assistance with most ADL's. R10's care plan, indicated R10 was hard of hearing and has difficulty with normal conversations. Care plan indicated qualified nursing staff would monitor for changes with my [R10's] abilities with communication and would offer to arrange hearing evaluation as needed. R10's electronic health record (EHR) lacked evidence R10 was offered an audiology appointment. During observation and interview on 2/10/25 at 4:04 p.m., R10 stated he had difficulty with hearing and asked surveyor to speak louder as it was really hard to hear people talking. R10 did not have hearing aides in his ears. R10 stated he had three pairs of hearing aids; one pair won't stay in ears and his daughter took the other two pairs home to see if she could get them fixed. R10 stated the facility had not discussed audiology services with him. During observation on 2/11/25 at 7:48 a.m., R10 did not have hearing aids present in ears. During observation on 2/12/25 at 5:54 p.m., R10 did not have hearing aids present in ears. During interview on 2/13/25 at 11:34 a.m., nursing assistant (NA)-C stated R10 was very hard of hearing and staff needed to speak louder for him to hear. During interview on 2/14/25 at 9:53 a.m., NA-D stated R10 was very hard of hearing, did not wear hearing aids and needed staff to talk loudly for him to hear. NA-D stated it may take R10 a couple of times for him to understand what is being said. During interview on 2/14/25 at 9:57 a.m., NA-E stated R10 was very hard of hearing, did not wear hearing aides and needed staff to speak loud to him to hear. During interview on 2/14/25 at 12:51 p.m., clinical manager (CM)-A stated a consent form was completed on admission for services such as podiatry, audiology and ophthalmology from outside provider who came to facility. CM-A stated if a resident was having general concerns, the services were discussed again. During interview on 2/14/25 at 3:31 p.m., CM-A stated she could not find documentation to indicate audiology services were discussed with resident. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/14/25 at 2:02 p.m., director of nursing (DON) stated if staff noticed a progression in hearing loss, facility should offer audiology services. DON stated staff could also check for wax buildup to see if could help with the resident being able to hear. She expected the resident was asked on admission if they would like audiology services and then it should be readdressed at every care conference. DON stated it was important to provide/assist with audiology services for his quality of life especially when R10 goes to dialysis as there was a community of individuals who go on the same schedule as R10 and being able to hear them was important so he can converse with them and be part of that community. The facility Hearing Impaired Resident policy, dated 1/25, indicated staff will assist hearing impaired residents to maintain effective communication with clinicians, caregivers, other residents and visitors. Staff will assist the resident (or representative) with locating available resources, scheduling appointments, and arranging transportation to obtain needed services. Staff will assist residents with the care and maintenance of hearing devices.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40938 Based on observation, interview and document review, the facility failed to implement care plan interventions to prevent pressure ulcers for 1 of 1 residents (R6), who were at risk to develop pressure ulcers. In addition, the facility failed to provide timely assistance with repositioning to promote healing of pressure ulcer for 1 of 1 resident (R25) in accordance with the individualized care plan. Findings include: R6's annual minimum data set (MDS) indicated R6 was severely cognitively impaired and was dependant on staff for cares. R6's pressure ulcer care assessment area (CAA) dated 11/21/24, indicated R6 was at risk for pressure ulcers due to needing physical assistance with bed mobility, was completely incontinent of bowel and bladder. R6's skin risk assessment with braden scale dated 1/30/25, identified R6 was at high risk to develop pressure ulcers and had interventions which included pressure reducing device on bed and wheelchair and heel protectors. R6's care plan revised 2/4/25, indicated R6 was at risk for impaired skin with interventions which included pressure relieving boots on feet while in bed. During observation on 2/10/25, at 12:23 p.m. R6 was in bed, pressure relieving boots were in chair. On 2/11/25, at 1:13 p.m. R6 was observed in bed sleeping on her right side, pressure relieving boots were in chair across the room On 2/12/25, at 1:39 p.m. R6 was observed in bed sleeping, laying on her right side, pressure relieving boots were nn chair across the room. When interviewed on 2/14/25, at 10:24 a.m. nursing assistant (NA)-E stated pressure relieving boots were on R6's feet during hours of sleep which included anytime R6 was in bed, including naps. When interviewed on 2/14/25, at 12:51 p.m. clinical manager (CM)-A stated pressure relieving boots were to be put on when in bed, come off when out of bed, this included during the day when naps were taken. When interviewed on 2/14/25, at 2:25 p.m. director of nursing (DON) stated the expectation was pressure relieving boots were placed on resident's [R6] feet anytime they were in bed to protect the heels to prevent pressure ulcers. 48013 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25 R25's quarterly Minimum Data Set (MDS) dated [DATE], identified R25 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R25's diagnoses included progressive neurological conditions, Parkinson's disease with dyskinesia (involuntary, erratic movements of the face, arms, legs or trunk), non-Alzheimer's dementia, anxiety disorder, adult failure to thrive and severe protein-calorie malnutrition. MDS indicated R25 was at risk for the development of pressure ulcers and currently had one stage four pressure ulcer (stage 4 ulcers are deep wounds that may impact muscle, tendons, ligaments, and bone). R25's care plan dated 1/8/25, identified R25 had a stage four pressure ulcer to right ischial tuberosity (large posterior bony protuberance on the superior ramus of the ischimum) and was at a high risk for altered skin integrity and pressure injuries and directed staff to reposition R25 every two hours while in bed and/or wheelchair. During continuous observation on 2/13/25 from 9:01 a.m. to 1:03 p.m. R25 was observed to be seated in a Broda (reclining wheelchair with bilateral supportive cushions) chair. At 9:01 a.m., hospice aide brought R25 to the common area to sit with other residents. At 10:03 a.m., R25 remained in common area watching television. At 11:11 a.m., R25 remained in common area watching television. At 12:38 p.m., R25 remained in common area watching television. At 12:49 p.m., R25 remained in common area watching television. At 1:03 p.m., staff assisted R25 to her room to assist R25 with laying down in bed to rest. During interview on 2/14/25 at 9:53 a.m., nursing assistant (NA)-D stated R25 was unable to reposition herself in her wheelchair and needs staff to assist with repositioning. NA-D stated R25 was to receive assistance with repositioning every two hours. During interview on 2/14/25 at 9:57 a.m., NA-E stated R25 needed to be turned and repositioned every two hours. During interview on 2/14/25 at 10:00 a.m., licensed practical nurse (LPN)-A stated R25 should be turned and repositioned every two hours. During interview on 2/14/25 at 12:51 p.m., clinical manager (CM)-A stated R25 had a pressure ulcer and needed to be turned and repositioned every two hours whether she was in bed or Broda chair. During interview on 2/14/25 at 2:02 p.m., director of nursing (DON) stated she expected staff to turn and reposition R25 every two hours. DON stated it was important for R25 to be turned and repositioned every two hours as R25 had current stage four pressure ulcer, had end stage Parkinson's, had no adipose tissue, was contracted and had very fragile skin. DON stated it was not appropriate R25 was not turned and repositioned every two hours per her care plan. The Individualized Care Plan Policy dated 10/26/22, indicated the facility would develop a comprehensive care plan using the comprehensive assessments, will individualize the plan of care to accurately reflect resident's functional capacity and medical, nursing, psychosocial, activity and other identified needs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Position a Resident in Chair/Wheelchair / Position - Side lying / Position - Supine policy, undated, indicated staff to provide proper positioning and good body alignment in order to prevent skin breakdown, relieve pressure and provide for better circulation. Nursing staff will provide resident with good body alignment and will reposition residents every 2 hours or more often as needed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on observation, interview and document review, the facility failed to comprehensively assess to assure safety with smoking for 1 of 1 resident (R13) who was smoking outside the facility. Findings include: R13's Continuity of Care document (CCD) printed 2/11/25, included diagnosis of tobacco use, weakness and dementia without behavioral disturbance. R13's quarterly Minimum Data Set (MDS) dated [DATE], identified R13 had intact cognition. R13's diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy, hypertension, non-Alzheimer's dementia, chronic obstructive pulmonary disease, dysphagia, unspecified mood disorder and peripheral vascular disease. R13's electronic health record (EHR) lacked evidence R13 was asked about or assessed for smoking. During the facility entrance conference on 2/10/25, the administrator and the clinical manager (CM)-A stated the facility did not have any residents who smoke as the facility was a non-smoking facility. R13's care plan printed 2/11/25, did not indicate R13 smoked. Progress note dated 6/29/24, indicated R13 yelled at multiple staff to take her outside and smoke. When staff refused, R13 went outside by herself and attempted to light a match on the building and was unsuccessful. R13 came back into building and yelled at staff to assist her with lighting her cigarette. When staff refused, R13 began yelling and this went on four different times between the times of 6:30 to 9:30 p.m. Note indicated R13 was feeling up staff for cigarettes and lighters. Progress note dated 8/2/24, indicated R13 was outside smoking and that she had a pack of cigarettes in her sweater. Staff approached R13 and asked for her cigarettes with R13 stating it was her last one. During the time R13 was outside, another staff member went into R13's room and found a pack of cigarettes, took them and placed them in the medication room. R13 approached staff later demanding her cigarettes back and stated staff had no right to invade her privacy and taking her pack of cigarettes. R13 was yelling and cursing at staff. Progress note dated 9/1/24, indicated staff assisted R13 with going outside. Staff walked back into the building and looked out window to see R13 attempting to light a cigarette with a lighter. Progress note dated 10/26/24, indicated R13 was seen outside the front entrance smoking. Progress note dated 11/6/24, indicated R13 was outside smoking and when R13 stood up there was a lighter under her leg. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress note dated 1/28/25, indicated R13 was seen outside smoking a cigarette that she had hidden after continually asking staff for one of her cigarettes. During interview on 2/11/25 at 12:02 p.m., R13 stated she was a smoker and would smoke if she had the opportunity. During interview on 2/11/25 at 1:47 p.m., nursing assistant (NA)-A stated R13 usually went outside to smoke, however it depended on how often as management stated she was not allowed to smoke. During interview on 2/12/25 at 1:36 p.m., NA-B stated R13 is a smoker, has gone outside to smoke several times, but was recently told that she is not allowed to smoke on grounds. During interview on 2/13/25 at 11:34 a.m., NA-C stated R13 will go out of facility and buy cigarettes and lighters. During interview on 2/13/25 at 12:13 p.m., registered nurse (RN)-A stated R13 liked to go outside frequently but is not able to as we are a non-smoking facility. During interview on 2/14/25 at 11:53 a.m., nurse practitioner (NP) stated the facility staff saw R13 smoking outside a lot. During interview on 2/14/25 at 12:51 p.m., clinical manager (CM)-A stated R13's family brought in cigarettes in for R13. CM-A stated she did not think a smoking assessment would be done for R13 as the facility is non-smoking. During interview on 2/14/25 at 2:02 p.m., director of nursing (DON) stated the facility was a non-smoking facility. DON stated a smoking assessment should have been completed when R13 was first seen out smoking. DON confirmed no smoking assessment had been completed for R13. The facility Tobacco/Smoke Free policy dated February 2025, indicated residents and/or their families or designated responsible party are informed during the admission screening process that we are a tobacco/smoke free facility. Resident who has history of smoking will be offered smoking cessation. Residents who do wish to continue to use tobacco, electronic cigarettes, or vape pens will be required to sign out in the Release of Responsibility for Leave of Absence book and go off facility property to use tobacco, electronic cigarettes, or vape pens.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to ensure the development of parameters for administration of heart rate control medication was assessed and implemented with pulse monitoring to ensure the parameters were met, if needed, to decrease the risk for complications for 2 of 5 residents (R13 and R40) reviewed for unnecessary medication use. Findings include: R13 R13's quarterly Minimum Data Set (MDS) dated [DATE], identified R13 had intact cognition. R13 was independent with bed mobility, sitting to standing and wheeling 50 feet with two turns. R13's diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy, hypertension, non-Alzheimer's dementia, chronic obstructive pulmonary disease (COPD), dysphagia, unspecified mood disorder and peripheral vascular disease. R13's care plan, print date of 2/11/25, indicated R13 was at risk for impaired cardiac function related to congestive heart failure, hypertension, hyperkalemia, atrial flutter, COPD, obesity, and type two diabetes mellitus. The care plan did not include digoxin (heart rate control medication) medication use and required monitoring. Care plan indicated staff would administer medications as ordered and monitor for signs and symptoms of cardiac distress such as altered vital signs, etc. R13's Order Summary Report dated 1/14/25, indicated R13 received 0.125 milligrams (mg) of digoxin once daily for atrial flutter. The order did not include parameters indicating when the medication should be held related to heart rate. R13's Medication Administration Record (MAR) dated 1/1/25 through 2/13/25, indicated R13 had received metoprolol (approximately) once daily during this period but did not include pulse measurements taken before digoxin administration. R13's Pulse Summary, print date of 2/13/25, identified three pulse measurements were obtained since 1/1/25, ranging from 54 to 63 beats per minute and indicated R13's last pulse measurement was dated 2/5/25. R13's history and physical summary dated 7/12/24, indicated R13 had atrial fibrillation and for staff to monitor heart rate. R40 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R40's quarterly Minimum Data Set (MDS) dated [DATE], identified R40 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R40's diagnoses included non-traumatic brain dysfunction, Alzheimer's disease with late onset, cancer, coronary artery disease, hypertension, peripheral vascular disease, pneumonia, hyperlipidemia, malnutrition, generalized anxiety disorder, major depressive disorder, COPD, paroxysmal atrial fibrillation, pan lobular emphysema, other obstructive and reflux uropathy, hallucinations, transient cerebral ischemic attack and benign prostatic hyperplasia with lower urinary tract symptoms. R40's care plan, print date 2/12/25, indicated R40 was at risk for impaired cardiac function related to atrial fibrillation, hyperlipidemia, history of NSTEMI and history of angina pectoris. The care plan did not include digoxin (heart rate control medication) medication use and required monitoring. Care plan indicated staff would administer medications as ordered and monitor for signs and symptoms of cardiac distress such as altered vital signs, etc. R40's Order Summary Report dated 1/14/25, indicated R40 received 0.25 milligrams (mg) of digoxin once daily for atrial fibrillation. The order did not include parameters indicating when the medication should be held related to heart rate. R40's Medication Administration Record (MAR) dated 1/1/25 through 2/13/25, indicated R40 had received metoprolol (approximately) once daily during this period but did not include pulse measurements taken before digoxin administration. R40's Pulse Summary, print date of 2/13/25, identified 12 pulse measurements were obtained since 1/1/25, ranging from 61 to 94 beats per minute and indicated R40's last pulse measurement was dated 2/9/25. During observation on 2/11/25 at 9:13 a.m., trained medication aide (TMA)-A went into R40's room and administered medications to R40 on a spoon mixed with pudding. TMA-A did not check pulse prior to administering medications. During interview on 2/11/25 at 9:15 a.m., TMA-A stated the nurses complete all the monitoring of medications and confirmed there were no vitals that she obtains prior to medication administration. TMA-A stated she had administered R40's pulse medication this morning. TMA-A stated she was unsure what his pulse was this morning or if it was safe to administer the medication as she had not measured R40's pulse. TMA-A stated the electronic medical record (EMR) notified her when she needed to take a resident's pulse and it did not for R40, so she had not taken it. During interview on 2/13/25 at 12:10 p.m., registered nurse (RN)-A stated there are no residents that need any vitals taken prior to administration of medications. RN-A stated pulse should be checked prior to administration of digoxin and if the heart rate is less than 60 beats per minute medication should be held. RN-A confirmed there was no order for pulse to be checked prior to administration of digoxin for R13 and R40. During interview on 2/13/25 at 1:12 p.m., TMA-A stated pulse should be taken before administering digoxin. TMA-A confirmed there was no order to check pulse prior to administering digoxin for R13 or R40 and confirmed she had not been obtaining pulse prior to administration. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/14/25 at 2:02 p.m., director of nursing (DON) stated she expected nursing staff to measure R13's and R40's pulse before giving the digoxin to ensure R13's and R40's safety as digoxin slows the heart down. DON stated she expected the provider to include parameters with the digoxin order so nursing staff would know when it was unsafe to give the medication and when they needed to notify the provider of pulse readings. DON stated she expected nursing staff to document pulse measurements taken prior to administering digoxin in the MAR. DON confirmed there were no orders in place for R13 or R40 and pulses were not being obtained prior to administration from digoxin. During interview on 2/14/25 at 3:22 p.m., consultant pharmacist (CP) stated it was standard practice to obtain pulse prior to administration of digoxin as medication should be held if pulse is less than 60 bpm. The facility Medication and Treatment policy and procedure, dated 1/24, indicated Digoxin should be administered on the noon medication pass with apical pulse obtained prior to administration.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40938 Based on observation, interview, and document review, the facility failed to monitor orthostatic blood pressures with the use of an antipsychotic medication for 4 of 5 residents (R1, R19, R7, and R13); failed to obtain signed consent with use of an antidepressant medication for 1 of 5 residents (R38); failed to implement other interventions before initiating antipsychotic medication for 1 of 5 (R38); failed to implement appropriate target behaviors for 1 of 1 resident (R1); and failed to have an appropriate diagnosis for 1 of 1 resident (R19) reviewed for unnecessary medications. Findings include: R1 R1's quarterly minimum data set (MDS) dated [DATE], identified R1 had severe cognitive impairment, required extensive assistiance with all activities of daily living (ADL's), and received antipsychotic and antidepressant medications. R1's dianoses included Alzheimers disease, age-related osteoporosis, anxiety, femur fracture, and repeated falls R1's physician orders included order for citalopram (antidepressant) 20 milligram (mg) by mouth daily for major depression; mirtazapine (antidepressant) 7.5mg by mouth daily for major depression and Alzheimers disease; and quetiapine (antipsychotic) 25mg by mouth twice daily for dementia. R1's medical record was reviewed and lacked any evidence orthostatic blood pressures had been obtained for R1. R1's record lacked evidence of blood test monitoring since 2022. R1's target behaviors (behaviors medication is intended to manage) include verbally abusive towards staff and number of times resident resisted cares. On 2/10/25 at 2:52 p.m., R1 was observed in her room looking out the window. During observation on 2/11/25 at 11:51 a.m., R1 was self-propelling wheelhcair in the hallway, R1 was calm with no negative verbalizations. When observed on 2/12/25 at 01:36 p.m. R1 was in the room reading a magazine outloud, no concerns regarding behavior were observed. When interviewed on 2/14/25 at 10:24 am. nursing assistant (NA)-E stated R1 banged on tables, would resist assistance from staff if attempted to remove pants or assisted with bathroom needs. During interview on 2/14/25 at 12:51 p.m. clinical manger (CM)-A stated clinical manager or director of nursing (DON) determined what target behaviors were monitored for psychotropic (drugs that affect a persons mental state) medications. CM-A stated was not aware of residents having orthostatic blood pressures monitored. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER St Clare Living Community of Mora		STREET ADDRESS, CITY, STATE, ZIP CODE 110 North 7th Street Mora, MN 55051	

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 2/14/25 at 2:02 p.m., DON stated orthostatic blood pressures should be monitored due to psychotorpic medications can cause orthostatic hypotension (condition when blood pressure significantly drops when a person stands up fro ma sitting or lying position) increasing risk of resident falling. DON stated herslef or clinical managers determined the target behaviors. Name calling, verbal abuse towards staff and resitance of cares were not appropriate target behaviors, residents had the right to refuse cares. DON stated she expected the resident's provider to ensure required blood tests were ordered or recommened by consulting pharmacist if they hadn't been completed. R19 R19s quarterly MDS dated , 1/10/25, identified R19 had severe cognitive impairment, required extensive assistance with all ADLs. R19's diagnoses included Alzheimers disease, psychosis, dementia, osteoarthritis, major depression, falls, coronary artery disease and hypertension. R19's phsyician orders included order for citalopram 20mg by mouth daily for major depression; mirtazapine 7.5mg by mouth daily for alzhemiers disease; quetiapine 25mg by mouth twice daily; amd quetiapine 50mg by mouth once daily for alzheimers disease. R19's target behavior for mirtazapine was sleeps for six to eight hours at night. Progress note dated 1/18/2025, at 2:51p.m. identified new order: Resident has been having increased agitation behaviors. Increase seroquel (quetiapine) to 50 mg for mid day dose. Continue 25 mg for A.M and P.M doses. However, review of R19's progress notes failed to indicate R19 displayed increased agitaion or behaviors. During observation on 2/11/25 at 8:59 a.m., R19 was sitting at a table in common area sleeping. On 2/11/25 at 1:12 p.m., R19 was observed sleeping in recliner in her room. When observed on 2/12/25 at 10:36 a.m., R19 was in the dining room waiting for brunch, with no bserved negative behaviors displayed. During observation on 2/12/25 at 5:55 p.m., R19 was in the dining room observing an activity. R19 was calm and quite. When observed on 2/13/25 at 8:24 a.m., R19 was in the dining room talking with nursing assistant voice was in calm even tones. When interviewed on 2/14/25 at 10:24 a.m., NA-E stated R19 did not have much for behaviors, R19 believed her spouse was in the room with her. NA-E stated she thought R19 was better than she had previously been. When interviewed on 2/14/25 at 1:24 p.m., NA-F stated R19 thought her husband was in the room with her but could not talk, R19 had no behaviors like yelling out or hitting. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 2/14/25 at 2:25 p.m., DON stated, sleeps six to eight hours was a goal not a behavior, there would be a sleep log that indicated a concern regarding sleep, R19 liked to be up at night with television on. DON stated she honestly did not feel that R19 required an increase in seroquel, behaviors had improved for the past six to eight months. DON reviewed progress notes, stated she did not see antyhing there that warrented an increase in the seroquel. 48013 R7 R7's quarterly Minimum Data Set (MDS) dated [DATE], identified R7 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R7's diagnoses included unspecified dementia with other behavioral disturbance, malnutrition, depression, varicose veins or right lower extremity with inflammation, peripheral vascular diseases, hypothyroidism, essential hypertension, osteoarthritis and systemic sclerosis. R7's medication and treatment record, print date of 2/11/25, indicated R7 had an order to monitor for orthostatic blood pressures (blood pressure drops when you go from lying down to sitting up, or sitting to standing) once monthly. R7's physician orders included orders for Zyprexa (antipsychotic) 2.5 milligram (mg) by mouth once daily for agitation. R7's medical record was reviewed and lacked any evidence orthostatic blood pressures had been obtained for R7 in the past five months. During observation on 2/11/25 at 8:47 a.m., R7 was ambulating independently with walker down hallway with staff walking next to her. R7's gait was steady but needed staff to walk next to her for supervision. R13 R13's quarterly MDS dated [DATE], identified R13 had intact cognition. R13 was independent with bed mobility, sitting to standing and wheeling 50 feet with two turns. R13's diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy, hypertension, non-Alzheimer's dementia, chronic obstructive pulmonary disease (COPD), dysphagia, unspecified mood disorder and peripheral vascular disease. R13's medication and treatment record, print date of 2/11/25, indicated R13 had an order to monitor for orthostatic blood pressures once monthly. R13's physician orders included orders for Seroquel (antipsychotic) 12.5 mg by mouth once daily for aggression and agitation. R13's medical record was reviewed and lacked any evidence orthostatic blood pressures had been obtained for since 12/12/24. Record indicated last orthostatic blood pressure obtained was on 12/12/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 2/14/25 at 10:00 a.m., licensed practical nurse (LPN)-A stated orthostatic blood pressures are obtained monthly. If orthostatic blood pressures are not able to be completed, she would reattempt later in shift, if possible, otherwise document resident refused in medication administration record (MAR). During interview on 2/14/25 at 11:53 a.m., nurse practitioner stated she prescribed Seroquel in 10/2024 as R13 was agitated and having angry outbursts with staff. NP stated nicotine withdrawal could be contributing to her behaviors. During interview on 2/14/25 at 12:51 p.m., clinical manager (CM)-A stated R7 had an order for orthostatic blood pressures to be obtained once monthly. During interview on 2/14/25 at 2:02 p.m., director of nursing (DON) stated she expected staff to obtain orthostatic blood pressures as ordered and if staff are unable to obtain blood pressures, they should reattempt again the next shift. DON stated orthostatic blood pressures are important to ensure resident was not having a significant difference in blood pressures that could lead to falls or fainting episodes due to the side effects of prescribed medication. DON stated if R13 was able to go out and smoke, she may not have exhibited behaviors of aggression and agitation and may not have needed to be prescribed Seroquel. During interview on 2/14/24 at 3:22 p.m., consultant pharmacist (CP) stated any resident on an antipsychotic medication should have orthostatic blood pressures obtained monthly. CP stated orthostatic blood pressures consist of obtaining a blood pressure when resident was lying, sitting, and then standing within the same timeframe. Pharmacist stated orthostatic blood pressures were important to monitor due to postural hypotension being one of the major side effects, especially in an older person, and would put the resident at a higher risk for falls when taking these medications. A facility Antipsychotic Medication Use policy, dated 12/24, indicated antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social, and environmental causes of behavioral symptoms have been identified and addressed. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician: Cardiovascular: orthostatic hypotension. R38 R38's quarterly MDS dated [DATE], identified R38 had intact cognition and independent with all activities of daily living (ADL)'s. R38's diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy, heart failure, hypertension, anxiety disorder, depression, chronic obstructive pulmonary disease and polyneuropathy. R38's physician orders included orders for Lexapro (antidepressant) 10 mg by mouth once daily for major depressive disorder. R38's medical record was reviewed and lacked any evidence signed consent had been obtained for Lexapro. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 2/14/25 at 2:02 p.m., DON stated consents should be obtained for all mood-altering medications as the resident has the right to know what medication was prescribed and decided if they want to take medication after reviewing potential side effects. During interview on 2/14/15 at 3:31 p.m., CM-A stated she was unable to find signed consent for R38's Lexapro. The facility Psychotropic Medication policy was requested but was not received.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 40938 Based on observation and interview, the facility failed to ensure correct use of personal protective equipment (PPE) to prevent the spread of COVID. This had the potential to affect all 4 residents, visitors and staff in short term stay unit. In addition, the facility failed to develop and implement a comprehensive infection control program that incorporated virasurveillance ofl infections and illnesses not treated with antibiotics to reduce the risk of spreading infections to other residents in the facility. This has the potential to affect all 44 residents who resided in the facility. Findings include: Mask and eye protection use During observation and interview on 2/10/25, at 1:58 p.m. registered nurse (RN)-A donned (put on) personal protective equipment (PPE) prior to entering COVID positive room. RN-A removed N95 mask from paper bag, placed on face then removed goggles from same paper bag, placed on face. RN-A stated that the facility had always reused the masks and goggles, placed inside paper bags when not in use. During observation on 2/11/25, at 10:10 a.m. overbed table was outside of COVID positive room containing 3 paper bags with staff names on outside of bags. On 2/12/25, at 10:47 a.m. observed overbed table with 7 paper bags labeled with staff names, one bag opened with edge of N95 mask out of paper bag. On 2/12/25, at 10:57 a.m. observed two unidentified staff members as they prepared to enter COVID positive room, both staff removed surgical mask from face, removed N95 mask and goggles from paper bag labeled with initials before surgical mask was placed into the same paper bag. When staff exited room, surgical mask reapplied from paper bag prior to N95 and goggles being placed back into the paper bags. When interviewed on 2/13/25, at 11:40 a.m. infection preventionist (IP) stated facility had adequate supply of PPE, staff labeled paper bag with their name or initials. N95 masks were reused for a full week as they have done since COVID first started. When IP was asked about surgical masks placed into paper bag and reused, IP stated new surgical masks should have been used to reduce the chance of spreading COVID. When interviewed on 2/14/25, at 2:58 p.m. director of nursing (DON) stated staff had reused N95 masks for the full shift. DON was reminded by IP there was no longer a mask shortage, new ones should be used when entering COVID positive rooms to help prevent the spread of COVID to other residents or staff. Facility policy titled Airborne Precautions dated 6/2019 indicated diseases transmitted through airborne transmission included but not limited to SARS (COVID). Heading of considerations identified resident placement and PPE as isolate resident in a private room, close the doors and alert staff. However, policy did not address the use of PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Infection Control Program The facilities infection control logs were reviewed form October 2024 through December 2024. January 2025 infection control log was requested; however, this was not provided. The facility provided documents with the month and year written along the top of the first page. The headings on the document included; unit, name, room number, admitted , existing infection from previous month (yes or no), infection type, body system of infection, surveillance definition (yes or no), symptoms, onset date, diagnostic test performed, test date, type of test, specimen source, test results, antibiotic resistant organism, antibiotic name, class, dose, route, frequency, provider, antimicrobial prescription origin, antibiotic end date, total days of therapy, meets criteria, antibiotic reassessment performed, transition based precautions required if yes specify and date symptoms resolved. There was no indication the facility included other infections not treated with antibiotics such as viral, fungal or yeast infections. Review of the facility infection control logs identified the following: October 2024 Infection Surveillance Log identified 14 residents listed. There were seven-line entries which identified the infection type of prophylaxis (preventative) with two entries contributed to one resident. Three-line entries addressed lower respiratory tract infections which were treated with antibiotic therapy. Three-line entries addressed urinary tract infections (UTI) which were treated with antibiotic therapy. Additionally, one line entry addressed cellulitis/soft tissue/wound infection which was treated with antibiotic therapy. There were no viral, fungal, yeast or viral illnesses identified, only illnesses that were treated with antibiotics. November 2024 Infection Surveillance Log identified 14 residents listed. There were seven-line entries which identified the infection type of prophylaxis (preventative) with two entries contributed to one resident. Six-line entries addressed urinary tract infections (UTI) which were treated with antibiotic therapy with two entries contributed to one resident. Additionally, two-line entries addressed cellulitis/soft tissue/wound infection which were treated with antibiotic therapy. There were no viral, fungal, yeast or viral illnesses identified, only illnesses that were treated with antibiotics. December 2024 Infection Surveillance Log identified 14 residents listed. There were seven-line entries which identified the infection type of prophylaxis (preventative) with two entries contributed to one resident. Three-line entries addressed cellulitis/soft tissue/wound infections which were treated with antibiotic therapy. Four-line entries addressed urinary tract infections (UTI) which were treated with antibiotic therapy. Additionally one line addressed upper respiratory tract infection which was treated with antibiotic therapy. There were no viral, fungal, yeast or viral illnesses identified, only illnesses that were treated with antibiotics. On 2/13/25, at 11:40 a.m. infection preventionist (IP) stated when residents have symptoms of infection it was written on daily report sheets and verbally passed on to the next shift, there was no tracking of infection symptoms or COVID infections on spreadsheets since they were not prescribed antibiotic therapy. IP stated facility had a COVID outbreak in December 2024, IP was nto able to confirm whether or not there were other infections that did not require antibiotics. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 2/14/25, at 2:58 p.m. director of nursing (DON) stated tracking on resident infections should include any resident that had symptoms of illness, not just those that were prescribed antibiotics. Tracking should include people on antibiotics to assist with determining what occurred with illness when no antibiotics had been prescribed which included tracking of any incidence of COVID to track location in the building and extent of any outbreak. Facility policy titled Surveillance stated 6/2019 indicated surveillance was used to identify conditions, practices, and processes that increase the risk of infections.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40938 Based on interview and document review, the facility failed to ensure 1 of 5 residents (R30) reviewed for immunizations were offered and/or provided the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 10/24, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over [AGE] years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after [AGE] years old. R30's face sheet, dated 2/13/25, indicated she was [AGE] years old. The immunization record dated 2/13/25, indicated R30 received the following pneumococcal vaccinations: PPSV23 on 1/1/04 and 12/5/18, she also received a PCV13 on 6/30/15. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R30 was offered or received PCV20. During an interview with infection preventionist (IP) on 2/13/25, at 11:40 a.m. IP stated has a worksheet for tracking of pneumococcal vaccines, upon checking spreadsheet IP stated R30 was not listed for PCV20 but should have been as R30's last pneumococcal vaccine was over six years prior. IP stated all infection control related policies were reviewed 1/2025, but has not yet updated policy content or review dates. A facility policy titled Pneumococcal Vaccines for Residents with a review date of 10/22, the policy did not address administer or offer PCV20 with shared decision making with provider.